No. 92-1074

IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY,

Petitioner,

v.

HARRIS TRUST AND SAVINGS BANK, as Trustee of the Sperry Master Retirement Trust No. 2,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF THE STATE OF NEW YORK AND THE COMMONWEALTH OF MASSACHUSETTS AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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The Attorneys General of the State of New York and the Commonwealth of Massachusetts respectfully submit this brief on behalf of the Superintendent of Insurance of the State of New York and the Commissioner of the Division of Insurance of the Commonwealth of Massachusetts as *amici curiae* in support of the Brief for Petitioner, the John Hancock Mutual Life Insurance Company ("John Hancock").

STATEMENT OF INTEREST OF *AMICI CURIAE*

The Superintendent of Insurance of the State of New York (the "Superintendent"), as head of the Department of Insurance (the "Department"), regulates the business of insurance in New York. The Superintendent is responsible for monitoring and regulating insurers that do business in New York, such as petitioner John Hancock. The Superintendent is required by law both to establish the nature and characteristics of the insurance products offered in New York, and to regulate the manner in which they are sold. In doing so, the Superintendent supervises the financial affairs of each of the insurers subject to his jurisdiction.[1] The group annuity contract that is the subject of this lawsuit ("GAC 50") was issued in New York and was reviewed and approved by the Department.

As of December 31, 1991, there were 87 life insurance companies domiciled in New York and another 60 licensed to do business in the State. In 1991, these insurers received premiums of more than $30 billion for all insurance products; they received premiums in New York totaling almost $19 billion for annuities alone, taking into account both individual and group annuities. *See* American Council of Life Insurance, *1992 Life Insurance Fact Book* 74 (1992). Nationwide, as of December 1991, life insurance companies under contract with retirement plans held approximately $746 billion in reserves. Of that $746 billion, $565 billion was held under general account contracts. *Id.* at 58. $394 billion was held under group annuity contracts like GAC 50.

The Superintendent's mandate is the protection of the insuring public through the enforcement of New York's comprehensive

1. Similarly, the Commissioner of the Division of Insurance of the Commonwealth of Massachusetts ("the Commissioner") is responsible for regulating insurance offered for sale to the public in Massachusetts.

legislation governing the business of insurance in New York. This legislation both ensures the financial stability of insurers doing business in New York and protects the public by strictly prohibiting unfair discrimination or inequitable treatment of policyholders and contractholders.[2] Given the significance of insurance transactions to the financial stability of the national and the New York economies, it is critically important for the Superintendent to regulate insurers' products and to demand proper accounting of insurers' obligations to ensure that they can make good on their promises. With a substantial proportion of the insurance industry's general account assets attributable to general account contracts with retirement funds, the present controversy poses problems of fundamental concern.

The Second Circuit's decision applies the fiduciary responsibility provisions of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001-1461 (1988)

2. In Massachusetts, similarly, among the Commissioner's most important functions is the determination of whether insurers are sufficiently stable financially to continue to issue and service insurance contracts. Comprehensive regulations govern the relationship insurers' assets must bear to their liabilities as well as the composition of insurers' capital. There are laws governing, for example, the computation of reserves, Mass. Gen. Laws Ann. ch. 175, §§ 9, 9A (West 1987), the determination and valuation of an insurer's assets and liabilities, *id.* at ch. 175, §11, and the manner in which an insurer may publish its assets and liabilities, *id.* at ch. 175, § 18. Massachusetts' insurance laws also: (1) set forth minimum standards for the commencement of business, including the examination by the Commissioner of the insurer's books and records, *id.* at ch. 175, § 32; (2) require the filing and establish the standards for the preparation of a uniform annual report, *id.* at ch. 175, §§ 25, 27; and (3) provide for periodic examinations by the Commissioner, *id.* at ch. 175, § 4. The quality and quantity of permissible investments is also strictly regulated. *Id.* at ch. 175, §§ 63-64 (investment limitations); *id.* at ch. 175, § 65 (mortgage loans); *id.* at ch. 175, § 66-66E (investments by domestic life companies).

("ERISA"), to an insurer's management and administration of its own general corporate assets. The Superintendent has a significant interest in reversing this conclusion for four reasons. First, the Second Circuit's decision will confound Congress's intention—and the common understanding of the insurance industry, the New York Department of Insurance, and the United States Department of Labor—that the regulation of insurance be left to the States. Second, application of the decision will severely impair the administration of the insurance laws by State insurance regulators. Third, the decision will interfere with the nondiscriminatory and equitable treatment of policyholders and contractholders required by State law. And fourth, the decision will interfere with the State's ability to ensure the financial stability of insurance companies operating in the State.

Taken together, these effects will undermine the heretofore successful effort of the State of New York to establish and implement a regulatory framework that assures a rational and stable insurance industry and fair and equitable treatment of all policyholders and contractholders.

SUMMARY OF ARGUMENT

Premiums paid to an insurance company under a group annuity contract such as GAC 50 become part of the insurer's general corporate assets, commonly known as the insurer's general account, unless they are allocated to a separate account.[3] An insurance company uses its general account to pay its operating expenses (*e.g.*, salaries, rent and taxes), obligations to general account

3. Under New York law, only fixed benefit payments may be made from an insurer's general account. New York law permits the payment of variable benefits, but only from a separate account. N.Y. Ins. Law § 4240 (McKinney 1985 & Supp. 1993); N.Y. Comp. Codes R. & Regs. tit. 11, § 50.1 *et seq.* (1993).

contractholders, obligations to creditors, and dividends to contract and policyholders. General account assets are not segregated for the benefit of any particular class of contractholders. Thus, all contractholders share equally in the security afforded by the undifferentiated general account. In monitoring the solvency of an insurance company, the Superintendent and the Department do not match specific liabilities with specific assets, but compare total liabilities with the general account's aggregate assets (though specific business lines are monitored on an asset-liability match basis).

For the exclusive benefit of one class of general contractholders—ERISA plans—and to the detriment of every other class, the Second Circuit's decision would require insurers to manage general account assets attributable to ERISA plan contractholders "solely in the interest of the [plan's] participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries." ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1) (1988). The decision could have the practical effect of requiring every insurer—somehow—to segregate from its currently undifferentiated general account those assets that are now to be subject to fiduciary treatment.

Such a requirement would impose extraordinary burdens upon both the industry and the Department and would raise unanswerable questions of equity and fairness. Just as significantly, it would be fundamentally inconsistent with the nature of insurance company general accounts and with their regulation under State insurance laws. The decision below intrudes into, and throws into disarray, the management and regulatory functions reserved to the States:

- By compelling insurers to give their own general account funds (that are deemed to be ERISA "plan assets" notwithstanding the ERISA plan's election to

buy a group annuity contract) preferential treatment in favor of ERISA contractholders, the Second Circuit would not only permit, but *require*, inequitable or unfair discrimination against other contractholders in violation of State law.

- Besides being an unfair preference in the eyes of State law, such special treatment of ERISA contractholders would undermine New York's comprehensive regulatory program governing the solvency of insurers. For sound financial reasons, that program prohibits "subclasses" for purposes of the distribution of assets of impaired or insolvent insurers in a liquidation or rehabilitation proceeding.

- Because an insurer's general account is presently undifferentiated, with no allocation of assets for specific policyholders and contractholders, there is no basis for determining which individual general account assets are to become "plan assets," much less the plan assets of a particular contractholder. Because different assets in the general account have different investment characteristics—for example, bonds, real estate, common stock, etc.—any scheme for the allocation of component assets of the general account to individual ERISA contractholders would necessarily be unimaginably cumbersome and inherently inequitable. Significantly, it is the nature of insurance and it is the fundamental economic objective of the insurance industry to *spread* risks, as the undifferentiated general account does. To require segregation of assets into hundreds or thousands of smaller, separately managed packages,

one for each ERISA contractholder, is exactly what the general account insurance contract is *not* designed to do.

- Because the Second Circuit would apparently accord "plan assets" a status separate and apart from other general account assets, it is now unclear whether these funds would be "admitted assets" that could be used to offset an insurer's general account liabilities, or indeed whether they would be assets of the insurer at all for statutory insurance accounting and solvency monitoring purposes. The decision thus would interfere with the Superintendent's ability to monitor and ensure the solvency of insurance companies, the insurer's ability to make investment and dividend decisions, and the public's ability to rely upon the accuracy of available financial information in making insurance-related decisions and evaluations.

These are not incidental intrusions on the regulation and business of insurance. They are profound changes that will affect insurers and insurance regulators nationwide, and that will confound the intent of Congress that the regulation of insurance be the exclusive province of the States.

This outcome is not the result of any clear, statutory directive; indeed ERISA and State insurance regulation have coexisted in relative peace since 1974. Rather, this problem arises from an interpretation of ERISA that ignores every explicit statutory attempt to harmonize State and federal law, and that misreads an explicit

statutory provision that disclaims any intention to regulate insurers' general account practices.[4]

In short, the decision below would appear to mandate a thorough restructuring of the insurance industry under a federal law that was never intended to interfere with the States' traditional responsibility to regulate that industry. It should be reversed.

ARGUMENT

THE SECOND CIRCUIT'S DECISION SHOULD BE REVERSED BECAUSE IT CONFLICTS WITH CONGRESS'S ALLOCATION OF THE REGULATION OF THE BUSINESS OF INSURANCE TO THE STATES

A. Congress Allocated The Responsibility For Regulating The Business Of Insurance To The States

The regulation of insurance is an area of traditional State regulation that Congress did not intend to preempt. *See FMC Corp. v. Holliday*, 498 U.S. 52, 62 (1990). Congress made this intention clear in the McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-1015 (1988)), which states:

> The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation and taxation of such business. . . . No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such act specifically relates to the business of insurance. . . .

15 U.S.C § 1012(a), (b) (1988). Because ERISA does not "specifically relate[] to the business of insurance," it cannot "invalidate, impair, or supersede" State law under McCarran-Ferguson. *Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978) (holding that ERISA does not preempt State law mandating benefits to plan participants because "[u]nder [the McCarran-Ferguson Act], the only congressional enactment which may 'invalidate, impair, or supersede' any state insurance law is an act which 'specifically relates to the business of insurance'") (citations omitted).[5]

Indeed, ERISA itself contains two provisions that preserve to the States the regulation of the business of insurance. First, section 514(d) states: "Nothing in [ERISA] shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . ." ERISA § 514(d), 29 U.S.C. § 1144(d) (1988). Under this provision, ERISA cannot be construed to regulate insurance, as this would violate the McCarran-Ferguson Act, which specifically reserves that power to the States.

Second, ERISA exempts State insurance law from federal regulation in Section 514(b)(2)(A): "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1988) (the "saving clause").

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4. ERISA excepts from fiduciary status an insurer's assets in connection with "an insurance policy or contract to the extent that such policy or contract provides for benefits the amount of which is guaranteed by the insurer." ERISA § 401(b)(2)(B), 29 U.S.C. § 1101(b)(2)(B) (1988).

5. *But see, e.g., Hewlett-Packard Co. v. Barnes*, 571 F.2d 502, 505 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978).

This Court examined the effect of the saving clause in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), when it held that ERISA did not preempt a Massachusetts State regulation mandating benefits for certain policyholders. The Court found that the State law "regulated insurance" within the meaning of the saving clause and thus could not be preempted by ERISA.

In deciding *Metropolitan Life*, the Court first noted that it "must presume that Congress did not intend to pre-empt areas of traditional state regulation." *Id.* at 740. "The presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope." *Id.* at 741. Once the Court determined that the law in question regulated insurance within the meaning of the saving clause, there could be no preemption. "If a state law 'regulates insurance,' . . . it is not pre-empted. Nothing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause . . . ." *Id.* at 746.

The Court also cited the McCarran-Ferguson Act to support its decision: "The ERISA saving clause, with its similarly worded protection of 'any law of any state which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." *Id.* at 744 n.21.

B. State Insurance Law Applies Even When State Law And ERISA Conflict

ERISA would "save" State insurance law even if there were a direct conflict between State law and a provision of ERISA. The plain language of the saving clause itself supports this conclusion: "*Nothing in this subchapter*"—whether or not it is in direct conflict with State law—"shall be construed to exempt or relieve any person from *any law of any State which regulates insurance*, banking, or

securities." ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1988) (emphasis added). In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), for example, a self-funded ERISA benefit plan contained a subrogation clause under which a plan member agreed to reimburse the plan for benefits paid if the member were to recover on a claim in a liability action against a third party. Pennsylvania law, however, expressly precluded subrogation by the plan, thus creating a direct conflict between the plan and State law. The Court stated that when ERISA and State law conflict, "[u]nless the statute is excluded from the reach of the saving clause by virtue of the deemer clause . . . it is not pre-empted." *Id.* at 61.[6] The Court recognized "Congress' presumed desire to reserve to the States the regulation of the 'business of insurance.'" *Id.* at 63.[7]

The Tenth Circuit has recently affirmed the power of the saving clause to displace ERISA in favor of State law in the event of a conflict. In *Winchester v. Prudential Life Ins. Co.*, 975 F.2d

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6. Under the deemer clause, ERISA § 514(b)(2)(B), 29 U.S.C. §1144(b)(2)(B) (1988), "an employee benefit plan governed by ERISA shall not be 'deemed' an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws 'purporting to regulate' insurance companies or insurance contracts." *FMC Corp.*, 498 U.S. at 58. The clause prevents regulation of self-insured plans by States purporting to regulate insurance. *Id.* at 61. The deemer clause has no bearing on this case.

7. Nothing in this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), suggests a contrary result. There the Court merely reaffirmed that the federal remedy provided by ERISA was the exclusive remedy for enforcing rights guaranteed under the statute. The Court held that any State-law claim seeking payment of benefits was preempted because the applicable State common law did not "regulate insurance" and thus was not protected from preemption by the saving clause. *Id.* at 50-51. Unlike the State law in *Pilot Life*, the New York laws at issue here, discussed below, "regulate insurance" and are thus protected by the saving clause.

1479 (10th Cir. 1992), the court recognized a potential conflict between Utah State decisional law and the terms of an ERISA benefit plan. The plan participant, a plant operator at an electrical power plant, suffered heart failure following a fire-fighting exercise. The plan's benefits included term life insurance and accidental death benefits. The insurance policy stated that accidental death benefits were conditioned on the employee's sustaining "an accidental bodily injury." Utah decisional law did not recognize heart failure after planned exertion as an "accidental bodily injury."

Relying on this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the court concluded "that the saving clause does save the Utah decisions at issue from preemption." *Winchester*, 975 F.2d at 1485. Though the terms of the ERISA plan's insurance policy arguably provided coverage for the accident, State law, not ERISA, governed the resolution of the dispute. *Id.*

To the extent that there is tension between ERISA and State law—and we submit that there is none because ERISA's guaranteed benefit policy exception applies—the controversy before this Court must likewise be resolved in favor of State law. Once within the saving clause, State statutes cannot be preempted, even when there is a conflict: "If a state law 'regulates insurance,' . . . it is not preempted." *Metropolitan Life*, 471 U.S. at 746.[8] Congress has demonstrated its clear intent to preserve for the States the power to regulate insurance: first in the McCarran-Ferguson Act, and twice more in ERISA Sections 514(d) and 514(b)(2)(A). The Second Circuit therefore erred in failing to effectuate Congressional intent to defer to the States in the regulation of insurance.

8. To suggest otherwise—that ERISA preempts State law when there is a conflict—would imply that the saving clause has meaning only when State law and ERISA are consistent. If that was Congress's intent, however, it could have made that clear—but did not.

C. Imposition Of ERISA's Fiduciary Responsibility Provisions On Insurers Would Create Irreconcilable Duties For Insurers And Profoundly Disrupt The State Regulation Of Insurance

The Second Circuit's decision would impose on insurers a duty to manage "plan assets" in their general account "solely in the interest of the [plan's] participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries." ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1) (1988). This imposition of ERISA's fiduciary standard would create irreconcilable duties for insurers in light of state insurance law requirements that all policyholders be treated in a fair and equitable manner, and would disrupt New York's regulation of general account assets and contracts.[9] The Second Circuit's decision should be reversed.

1. The Second Circuit's Decision Creates a Conflict Between State Law And ERISA

It is not the objective of *amici* to advocate constructions of a federal statute. Nonetheless, the Second Circuit's extension of ERISA is premised upon an attenuated construction of statutory language that does not, by its terms, appear to compel the kind of sweeping systemic upheaval that State regulators now face. Besides refusing to preempt State insurance law generally, ERISA in fact explicitly excepts from fiduciary status "guaranteed benefit policies." A guaranteed benefit policy is an "insurance policy or contract to the extent that such policy or contract provides for

9. Massachusetts' comprehensive regulatory scheme for insurance companies would likewise be frustrated by the imposition of ERISA's fiduciary standard to general account contracts. *See* note 2, *supra*.

benefits the amount of which is guaranteed by the insurer." ERISA § 401(b)(2)(B), 29 U.S.C. § 1101(b)(2)(B) (1988).

Now, almost twenty years after the initial passage of ERISA, the Second Circuit has suddenly isolated the guaranteed benefit policy provision without regard for business and regulatory realities. Relying on a nuance, the Second Circuit would bifurcate group annuity contracts and, inadvertently but inevitably, undermine the State regulatory scheme.[10]

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10. While general account contracts like GAC 50 guarantee a benefit to plan participants regardless of an insurer's investment performance, they also participate in the favorable investment experience of the insurer's general account by receiving an allocation of net investment income. Consequently, the book value of the premiums paid to the insurer, combined with any income or dividends allocated to the contract, less the amount of any benefits previous paid, may exceed the contractual cost of the guaranteed benefits. The term "free funds" is used colloquially to refer to this book value excess.

The opinion below in effect bifurcates a single group annuity contract into two separate contracts, one for the "book value" of the benefits guaranteed under the contract, the other for the "free funds." It should be emphasized that there is no state regulatory basis for creating, let alone precisely defining, such a thing as "free funds."

Perhaps more important for present purposes, there is in place no regulatory system at all that would permit, let alone effectively implement, a financial bifurcation of individual contracts into component parts to be treated differently. Although the Second Circuit takes pains to limit its holding to "free funds," as if that were a helpful distinction, the Superintendent has no current comprehension of how to implement such a scheme in real life.

If the "free funds" are viewed as the favorable net investment experience of the insurer, they are not unlike the divisible surplus that can accrue on participating life insurance policies and annuity contracts subject to Section 4231 of the New York Insurance Law. Participating cash value (continued...)

ERISA itself does not call for any such bifurcated scheme. The Second Circuit relied upon a fragment of equivocal legislative history to support its line of thought, along with inapposite advisory opinions by the Department of Labor ("DOL"). Although it has enforced the fiduciary responsibility provisions of ERISA for almost twenty years, DOL appears never to have asserted jurisdiction over an insurer's general account, and has promulgated no regulations of which New York is aware to govern the conduct of insurers in New York or any other State. Moreover, DOL has unambiguously stated that general account assets are not plan assets under ERISA. *See* Interpretive Bulletin 75-2, 29 C.F.R. § 2509.75-2 (1991). Evidently acknowledging the intention of Congress as expressed in both the McCarran-Ferguson Act and the saving clause of ERISA itself, DOL has left the business of regulating the insurance industry to the States.

Similarly, the insurance industry itself has never understood ERISA to have the profound impact on the regulation of insurance that the Second Circuit's decision would impose. The industry has never undertaken to develop insurance products that would accommodate the bifurcated obligations that the Second Circuit is imposing through its reading of ERISA.

Thus, the Second Circuit's conclusion that Congress intended ERISA to encompass insurers' own management of premiums paid pursuant to arms-length contracts between insurers on the one hand

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10.(...continued)
life insurance has been used as a funding vehicle for retirement plans, especially small plans, for decades. The Superintendent is concerned that the reasoning of the Second Circuit would also apply to participating cash value life insurance policies, bifurcating the guaranteed cash value of the policy and the dividends that may have accrued, and requiring that the insurer's divisible surplus be subject to fiduciary treatment under ERISA.

and ERISA plan fiduciaries on the other takes ERISA into territory that Congress has never in fact traveled. Indeed, it was to avoid that terrain—to leave to the States the complex and intricate job of assuring a functional insurance industry—that Congress explicitly excepted guaranteed benefit policies from ERISA. Congress chose to impose substantial responsibilities on *plan trustees* and *advisors* to select the right financial products from the extensive menu offered by the insurance and financial industries.

Furthermore, in stretching ERISA to regulate general account assets, the Second Circuit did not consider the State's exclusive responsibilities for insurance regulation. *See* Opinion of the Second Circuit, *passim*. Indeed, it is the magnitude of the adverse implications for State regulation arising from the Second Circuit's decision—which the opinion below never discusses—that most powerfully demonstrates the Second Circuit's error.

2. The Second Circuit's Decision Undermines Basic Insurance And Financial Principles And Conflicts With State Statutory Schemes For Monitoring The Solvency Of Insurers

The underlying purpose of insurance is the provision of contractually specified benefits that may come due at some future date. Assuring the ability of an insurer to meet these obligations is a central goal of New York's and Massachusetts' systems of insurance regulation. Requiring an insurer to act solely in the interest of a favored sub-group of participants and beneficiaries, however, would frustrate the regulators' ability to monitor an insurer's solvency and financial well-being under the statutory accounting practices mandated by State law.

The fundamental traditional financial benchmark for ascertaining an insurer's financial condition is a comparison of the insurer's total admitted assets (as defined in Section 1301 of the

Insurance Law of the State of New York) with the total amount of its other liabilities.[11] Admitted assets are grouped for statutory financial reporting purposes by category (*i.e.*, common stocks, preferred stocks, bonds, real estate, mortgage loans, etc.). Section 1301(a) of the Insurance Law requires that an admitted asset be owned by the insurer. General account funds are *owned by insurers* regardless of their source. This general, undifferentiated pool of assets, owned by the insurer, is the heart of its financial stability.

The Second Circuit's decision undermines this scheme by redefining funds that it deems under ERISA to be subject to special fiduciary treatment. As noted above, this special treatment would affect a substantial portion of the assets in general accounts. By the Second Circuit's view, these "free funds" are no longer assets beneficially owned by the insurer as the Department has previously understood and applied that term. If an insurer is regarded as an administrator of funds that it must manage exclusively for the benefit of a plan (because they are plan assets), those funds should not be viewed as assets of the insurer available to be offset against its liabilities. An inability to treat those funds as admitted assets could create an imbalance in an insurer's admitted assets on the one hand and its liabilities on the other, potentially creating the basis for a determination that it is insolvent. N.Y. Ins. Law § 1309(a) (McKinney 1985).[12] Under New York statutory provisions, the

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11. Insurers licensed in New York are required to maintain a minimum "surplus to policyholders," as set forth in the Insurance Law, based upon the lines of business that they write. Section 107(a)(42) defines the surplus to policyholders as "the excess of total admitted assets over the liabilities of an insurer."

12. Obligations to pay out proceeds pursuant to the terms of group annuity contracts are carried currently as general company liabilities, again without differentiation or regard to beneficiary. Thus, although

(continued...)

Superintendent would then be authorized to suspend or revoke the license of a foreign or alien insurer or to place a domestic insurer in rehabilitation or liquidation. N.Y. Ins. Law §§ 1309(b), 7402(a) & 7404 (McKinney 1985).[13]

In essence, the Second Circuit's decision can be construed to create a new category of asset (if it is an asset of the insurer at all) not specifically authorized by State law. On the one hand, funds subject to ERISA fiduciary treatment are not necessarily general account assets against which the general liabilities of the insurer can be offset. On the other, it is clear that they are not separate account

12.(...continued)
reallocation of both assets attributable to ERISA plan customers (from general account assets) and corresponding liabilities for monies eventually owing to those customers does not create an imbalance *for those customers*, it does completely transform *the insurers*' financial situation. *First*, under the Second Circuit's decision, funds attributable to ERISA plans would simply be unavailable to the owned-capital base of the insurer, upon which its ability to take on and pool risks depends. *Second*, one must question whether fiduciary funds may be used in any way to conduct the very business of insurance, *i.e.*, the devotion of capital to cover risk for a projected profit.

13. Likewise, under the Risk-Based Capital Model Act of the National Association of Insurance Commissioners ("NAIC"), with which all States will eventually comply in order to obtain or maintain their accreditation from the NAIC, every life insurer will have to file with the Department of Insurance in its domiciliary state a risk-based capital report. The report solicits information about four different kinds of risks undertaken by every insurer—asset risks, insurance risks, business risks, and all other risks—to evaluate the sufficiency of each insurer's capitalization. Because the calculation of asset risks is based on those assets classified as admitted assets for financial reporting purposes, a determination that plan assets in an insurer's general account are not "admitted assets" will complicate and confuse any analysis of an insurer's financial health.

assets immune to such offsetting.[14] They are, apparently, a judicially created hybrid, a general account asset that may not be used to satisfy claims on the general account. The creation of this hybrid "asset," if accepted, would have powerful adverse effects on the ability of insurers to conduct business and on State regulators to monitor that business. If a large portion of the insurers' undifferentiated general account—i.e. its capital base—were reallocated to a series of specially-managed fiduciary accounts, the general account would be deprived of a huge pool of assets. Assessing the financial stability of thousands of participants in that network, under as yet indeterminable legal and financial standards, is a daunting task. Moreover, one must consider whether the insurance industry as we know it can remain viable when its capital base is reallocated, legally or otherwise, among various accounts. If insurers are no longer able to manage a substantial portion of their general account for the benefit of all general account contractholders, and cannot utilize that now-segregated capital to take on risks (because they are deemed to be fiduciaries to risk-averse pensioners), the business of insurance will (at a minimum) have to be reconstructed.

14. Separate account assets, while assets of the insurer, may not be used to satisfy claims on the insurer's general account. Section 4240 of the Insurance Law, governing separate accounts, provides the exclusive means for insulating assets from general account liabilities. Under a separate account arrangement, the annuity contractholder assumes the insurer's investment risks, and the assets are segregated from the liabilities of the insurer's general account and other separate accounts maintained by the insurer for other contractholders. Such separate account assets are specifically excluded from the estate of a domestic life insurer in applying the scheme for the distribution of claims of Section 7435. To the extent that the Second Circuit's decision attempts to insulate assets from general account liabilities through its imposition of fiduciary treatment on certain assets in the general account, it does so inconsistently with Section 4240.

From the point of view of the purchaser of an insurance policy, be it a life insurance policy or otherwise, access to these now-segregated accounts to pay claims cannot be considered a given. Although the decision below fails to elaborate, it would appear that its imposition of ERISA duties on insurers is premised upon the notion that funds acquired by insurers by selling group annuity contracts to ERISA plans continue to be beneficially owned by those plans, and must be used solely in the interests of those plans. To the extent that this premise precludes access to those funds to pay insurance claims of general account policyholders, or involves even a new preference in paying out an insolvent insurer's assets first for the claims of ERISA participants before the claims of other general account policyholders, one must expect a dramatic loss of market confidence in insurers' abilities to provide security.

It is the Superintendent's view that, fundamentally, purchasers of insurance company group annuity contracts are purchasing insurance products that guarantee the payment of retirement benefits to plan participants and permit participation in the positive experience of the insurer's general account. They are not, and have never been, purchasing an investment advisory service subject to federal regulation. To the extent that the decision below requires reallocation of the capital base of insurers, it is antithetical to the very nature of insurance and, paradoxically, will deprive ERISA plans of the protection they thought they had purchased as part of the insurer's general account.

3. The Second Circuit's Decision Would Massively Complicate An Insurer's Ability To Make Investments

The primary purpose of the investment provisions of New York's Insurance Law is to restrict the types, quality, and amounts of assets acquired by insurers to ensure that insurance companies will be financially solvent and able to pay their policyholders' claims. 1 Wolcott B. Dunham, Jr., *New York Insurance Law* § 8.01[1] (1992). Section 1405 of the Insurance Law sets forth the permissible investment categories, and expresses investment limitations as a percentage of admitted assets. *Id.* § 8.04[1]. For example, Section 1405(a)(2) permits investments in the obligations and preferred shares of American institutions, "provided, however, that . . . the aggregate amount of investments in preferred shares of such institution made under this section *shall not exceed two percent of the insurer's admitted assets.*" (emphasis added).

Because, after the Second Circuit's decision, it is no longer clear whether "plan assets" constitute "admitted assets," affirmance of the decision below would throw New York's entire system for regulating permissible investments into confusion. If plan assets are not admitted assets against which the general liability of an insurer can be offset, then insurance companies relying on Section 1405 limitations may have overinvested in otherwise permissible categories of investments, perhaps to the detriment of all of their general account policyholders. Divestment, reinvestment and/or a basic rewrite of the State regulatory system could be required.[15]

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15. At the very least, any allocations of existing investment assets between ERISA contractholders and non-ERISA contractholders may require insurers, as ERISA fiduciaries, to allocate better performing assets to ERISA contractholders, with poorer performing assets allocated to non-ERISA contractholders. Furthermore, it is unclear how assets are to be

(continued...)

4. The Second Circuit's Decision Requires Insurers, In Violation Of State Law, To Discriminate Against The Holders Of Contracts Not Subject To ERISA

Generally, insurance is the equitable spreading of risk among a large number of policyholders or contractholders backed by the pooled assets of the insurer's general account. Those pooled assets are available to satisfy claims made under each of the policies or contracts. New York pursues its goal of equitable treatment of policyholders through a number of statutory provisions;[16] the Second Circuit's decision would frustrate the effectiveness of those provisions.

Section 4224(a)(1) of the Insurance Law, for example, states:

> (a) No life insurance company doing business in this state and no savings and insurance bank shall:
>
> (1) *make or permit any unfair discrimination between individuals of the same class* and of equal expectation of life, in the amount or payment or return of premiums, or rates charged for policies of life insurance or annuity contracts, or in the dividends or other benefits payable thereon, *or in any of the terms and conditions thereof* . . . .

N.Y. Ins. Law § 4224(a)(1) (McKinney 1985) (emphasis added). Similarly, Article 74 of the Insurance Law, which sets forth procedures for the rehabilitation and liquidation of domestic insurers, establishes priorities for the distribution of the general account assets of an insurer's estate among claimants, including annuity contract claimants. Section 7435(a) specifies that, within each of the eight classes established for the distribution of assets, "[n]o subclasses shall be established."[17]

By requiring insurers in effect to afford certain contractholders preferential treatment over others, the Second Circuit's decision compels precisely the kind of unfair discrimination prohibited by Section 4224, and precisely the type of subclass explicitly rejected by Section 7435.[18] Under the Second Circuit's decision, an insurer faced with two contractholders, one an ERISA plan and one not, must favor the ERISA plan contractholder with fiduciary treatment

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15.(...continued)
allocated to each ERISA contractholder consistent with the fiduciary duties imposed upon the insurer by ERISA.

16. *See, e.g., Health Ins. Ass'n of Am. v. Corcoran*, 551 N.Y.S.2d 615, 618 (3d Dep't), *aff'd*, 565 N.E.2d 1264 (1990) ("'The function of [the Department of Insurance] is to ensure equity both to policyholder and company, not only in rates but in the extremely important realm of giving the public proper coverage in return for premium payments.'") (quoting *Public Serv. Mut. Ins. Co. v. Levy*, 387 N.Y.S.2d 962, 964 (Sup. Ct. N.Y. Co. 1976), *aff'd*, 395 N.Y.S.2d 1 (1st Dep't 1977).

17. Section 7435(b) does permit an exception for claims under a "separate account":

> Every claim under a separate account agreement providing, in effect, that the assets in the separate account shall not be chargeable with liabilities arising out of any other business of the insurer shall be satisfied out of the assets in the separate account equal to the reserves maintained in such account for such agreement . . . .

Section 7435(b) is a statutorily created exception with no application to the general account funds at issue in this litigation.

18. Because Section 7435 groups all claims made under insurance policies and annuity contracts in a single class, any disparity in the treatment of annuity contractholders based upon their status under ERISA would effectively create a subclass in violation of Section 7435.

to which the other is not entitled.[19] Even if the terms of their contracts were identical, federal law would superimpose a differentiation that is not there and was not there when the contracts were purchased. It would, for example, require insurers to make investment decisions for ERISA contractholders based upon a different standard from that applied to other contractholders of the same class, perhaps to the detriment of such other contractholders, and possibly to allocate income and expenses to ERISA contractholders on a preferential basis. Such a result is inconsistent with the basic investment and income and expense allocation standards embodied in Articles 14 and 42 of the Insurance Law, and contrary to statutory provisions intended to promote equitable treatment of and avoid unfair discrimination among the holders of policies or contracts.[20] This result contradicts ERISA's saving

19. Under New York law, an insurance company is not a fiduciary to its policyholders. *See, e.g., Rochester Radiology Assocs. v. Aetna Life Ins. Co.*, 616 F. Supp. 985, 988 (W.D.N.Y. 1985); *Rhine v. New York Life Ins. Co.*, 289 N.Y.S. 117, 130 (1st Dep't), *aff'd*, 6 N.E.2d 74 (1936). An insurance company has long had discretion under New York law in the management of its assets. *Rhine v. New York Life Ins. Co.*, 6 N.E.2d 74, 80 (N.Y. 1936).

20. Section 1405 of the Insurance Law regulates generally the investments of life insurers. Section 4239 authorizes the Superintendent to promulgate regulations "prescribing standards for the *equitable allocation of income and expenses* as among lines of business and as between investment expenses and insurance expenses" by life insurers (emphasis added). These standards, as established by Insurance Department Regulation No. 33, indicate that "[i]t is the responsibility of each life insurer to use only such methods of allocation as will produce a suitable and equitable distribution of income and expenses." N.Y. Comp. Codes R. & Regs. tit. 11, § 91.4(a)(1) (1993).

Other provisions of the Insurance Law also prohibit discrimination of the type the Second Circuit's decision requires. Section 3201 of the (continued...)

clause, and is inconsistent with the principles of fairness that are the foundation of New York's regulation of insurance.

5. The Second Circuit's Decision Creates Unanswerable Questions Of Fairness Regarding The Segregation Of "Plan Assets"

The segregation of "plan assets," if possible, would undermine principles of fairness in another sense as well. Because the assets in an insurer's general account are undifferentiated, there is no principled basis for treating any asset as a "plan asset" and others not. Any allocation would, fundamentally, be either arbitrary, unfair to all general account policyholders, or tautological. Insurers could, one imagines, allocate an undifferentiated percentage share of current general account assets to each of the thousands of ERISA plan investors. This approach, however, would render the decision below essentially meaningless.

The Second Circuit seems to be requiring that ERISA plan customers receive tailored asset packages designed by insurer personnel who are now ERISA plan fiduciaries. Because, however, some assets are more desirable—have a greater potential for profitability—than others, and any investment offers a distinctive mix of risk and potential reward, any special allocation of existing

20.(...continued)
Insurance Law authorizes the Superintendent to reject "any form of annuity contract . . . for delivery or issuance for delivery in this state, *if its issuance would be prejudicial to the interests of policyholders or members or it contains provisions which are unjust, unfair or inequitable.*" N.Y. Ins. Law § 3201(c)(2) (McKinney 1985) (emphasis added). The Second Circuit's decision would effectively incorporate obligations into annuity contracts purchased by ERISA plans that would unfairly discriminate against other holders of general account contracts to which ERISA does not apply.

assets to pension plans will inevitably be unfair to those to whom the more desirable assets are not allocated. This will expose insurers, inevitably, to multiple lawsuits by disgruntled non-ERISA customers, and by unhappy ERISA plans (that purchased an undifferentiated share of a large pool of many types of assets and end up with their own mini-mutual fund).[21] It may, in addition, hobble the ability of the insurer to meet guarantees made to non-ERISA policyholders. The Second Circuit's decision would in effect require the intervention of the legislatures of all fifty States to resolve a dilemma that, from the State regulator's point of view, should never have arisen at all. Congress cannot have intended such a dramatic intrusion on a heretofore fully functional and fair regulatory system.

D. Application Of The Second Circuit's Decision Would Enormously Complicate The State Regulation Of Insurance

The application of the Second Circuit's decision will have an enormous impact both on the administration of the Insurance Law by the Department and on the insurance industry's handling of the billions of dollars contributed under group annuity contracts such as GAC 50. The ruling will expose insurers to potentially large liabilities for breach of heretofore unimagined fiduciary obligations under ERISA, including challenges to investment, income allocation, and dividend practices that comply with State law. Insurers will somehow also have to bring their general accounts into compliance with State law, notwithstanding the court-mandated

21. Because this potential for liability (and the uncertainty regarding the status of general account assets subject to ERISA fiduciary obligations) would apply only to insurers writing ERISA-related business and would have the most severe impact on those insurers with the largest volume of such business, affirmance of the Second Circuit's decision could deter insurers from writing such contracts at all.

reallocation of most of those assets; or, more likely, it will require a thorough rewrite of State law itself.

If upheld, the Second Circuit's decision would effectively require a two-tiered regulatory scheme that the Department would have to oversee in areas of insurance law involving ERISA-covered pension plans: one State-law tier applying to non-ERISA funds and ERISA funds not considered plan assets, and one federal tier for funds deemed plan assets. As demonstrated above, such a change would necessarily and extensively complicate the Department's regulation of insurance, including the Department's evaluation of the solvency of insurers.[22]

To avoid what can accurately be described as a dramatic and unwarranted revolution in the regulation of insurance in all fifty States—and in keeping with the common understanding of Congress, the New York and Massachusetts Departments of Insurance, the United States Department of Labor, the insurance industry, and its customers—the Court should reverse the Second Circuit's decision.

22. Until now, all general account assets of an insurer have been available to satisfy all of the insurer's general obligations, without regard to the identity or status of particular policyholders or contractholders. Insurers have to date prepared financial statements and the Department has reviewed them on that basis. The Second Circuit's decision, however, suggests that certain general account assets may not be available for those purposes, and therefore calls into question the accuracy of the information currently provided in such statements. It should be noted that a wide segment of the public, including policyholders, contractholders, lending institutions, investors, investment bankers, reinsurers, and other insurers, relies on insurers' statutory financial statements for accurate information regarding admitted assets and liabilities.

CONCLUSION

For all the foregoing reasons, *amici curiae* the Attorneys General of the State of New York and the Commonwealth of Massachusetts, on behalf of the Superintendent of Insurance of the State of New York and the Commissioner of the Division of Insurance of the Commonwealth of Massachusetts, respectfully urge this Court to reverse the decision of the United States Court of Appeals for the Second Circuit.

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